

EMERGENCY TREATMENT RELEASE FORM

Dear Parent/Guardian:

In order to serve your child in case of accident or sudden illness either at school, on a field trip, or any school sponsored activity, it is necessary that we have this release form signed. Please complete the information requested on the back of this form, review the statement below, then sign and return this form to your child's homeroom teacher on the next school day.

Student's Last Name	First Name	Middle Initial
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I the undersigned, do hereby authorize officials of _____ Public Schools to contact the persons named on the reverse side of this form and do authorize the named physician or EMS personnel to render such treatment as may be deemed necessary in an emergency, for the health of said child.

In the even the parent/guardian, physician or other persons named on the reverse side of this form cannot be contacted, officials of _____ Public Schools are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of said child.

I will not hold the school district financially responsible for the emergency care and/or transportation of said child.

Signing this form shall release _____ Public Schools and staff members from any liability of any nature in assisting said child during a medical emergency.

Signature of Parent/Guardian

Date

Important:

1. If an accident or illness occurs, a copy of this form will be provided to the emergency care provider (physician, hospital, EMS).
2. If any of this information changes during the year, please call the school office.
3. Please complete, sign and return this form to your child's homeroom teacher on the next school day.
4. Please complete all of the information requested.

EMERGENCY INFORMATION FORM

Date: _____ School: _____

Full Name of Student: _____
Last First Middle

Teacher: _____ Grade: _____ Date of Birth: _____

Student's Address: _____

City/State: _____ Zip Code: _____ Telephone: _____

Parent(s) or Guardian(s): _____

Place of Employment (**Father**/Guardian) _____

Where do we contact you in case of an emergency?

(If no home phone, provide the name or a relative or neighbor and their phone) _____

Home Phone: _____ Cell/Pager: _____ Work: _____

Place of Employment (**Mother**/Guardian) _____

Where do we contact you in case of an emergency?

(If no home phone, provide the name or a relative or neighbor and their phone) _____

Home Phone: _____ Cell/Pager: _____ Work: _____

Who do we contact if you cannot be reached?

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Please complete this section to allow your child to be taken for treatment in case of emergency, when neither you nor the persons listed above can be contacted: *"I give permission for my child to be taken by school personnel or ambulance for treatment to _____ Hospital emergency for treatment. I will be responsible for all related fees."*

Physician's Name: _____ Patient's File Name: _____

Address: _____ Phone: _____

Health Insurance Company _____

Name of Policy Holder: _____ Policy Number: _____

Preferred Ambulance Service, if other than EMS _____ Phone: _____

Use space below to list any health condition(s), routine medication(s), or substances that cause your child to have a severe allergic reaction requiring immediate emergency treatment:

Health Condition	Medication	Allergen/Emergency-Care Needed

If student has medical equipment or supplies, please list company or supplier:

Supplier: _____ Phone: _____

Jefferson County Public Schools

Jefferson County Public Schools Standard Student Accident Report Form Part A. Information on ALL Accidents			
1. Name _____		Home Address _____	
Last _____ First _____		Sex: M <input type="checkbox"/> F <input type="checkbox"/> ; Age _____ Grade or classification _____	
2. School _____		3. Time accident occurred: Hour _____ A.M. _____ P.M. _____ Date _____	
4. Place of Accident: School Building <input type="checkbox"/> School Grounds <input type="checkbox"/> To or from School <input type="checkbox"/> Home <input type="checkbox"/> Elsewhere <input type="checkbox"/>			
5.	Nature of Injury	Abrasion _____ Fracture _____ Amputation _____ Laceration _____ Bruise _____ Puncture _____ Burn _____ Scratches _____ Concussion _____ Sprain _____ Cut _____ Other (Specify) _____	Description of Accident How did accident happen? What was student doing? Where was student? List specifically unsafe acts and unsafe conditions existing. Specify any tool, machine, or equipment involved. _____ _____ _____ _____ _____ _____
	Part of Body Injured	Ankle _____ Hand _____ Arm _____ Head _____ Back _____ Knee _____ Elbow _____ Leg _____ Eye _____ Nose _____ Face _____ Scalp _____ Finger _____ Tooth _____ Foot _____ Wrist _____ Other (Specify) _____	
6. Name of Doctor or Hospital _____			
7. Degree of injury: Death <input type="checkbox"/> Permanent Impairment <input type="checkbox"/> Serious but not permanent <input type="checkbox"/> Minor <input type="checkbox"/>			
8. Number of days lost from school _____			

B.L.C. 168-175-1 F-442-1

Send to Safety/Security Office, C. B. Young, Jr., Service Center.

MAC 6/9/92

Part B. Additional Information on School Jurisdiction Accidents		
9. Teacher in charge when accident occurred (Enter name.) _____		
Present at scene of accident No _____ Yes _____		
10.	Immediate Action Taken	First-aid treatment _____ By (Name) _____ Sent home _____ By (Name) _____ Sent to physician _____ By (Name) _____ Name of physician _____ Sent to hospital _____ By (Name) _____ Name of hospital _____
11. Was a parent or other individual notified? No _____ Yes _____ When _____ How _____		
Name of individual notified _____		
By whom? (Enter name.) _____		
12.	Specify Activity	Remarks
Location	Athletic field _____ Auditorium _____ Classroom _____ Corridor _____ Dressing room _____ Gymnasium _____ Home Econ. _____ Laboratories _____ Sch. Grounds _____ Shop _____ Showers _____ Stairs _____ Other _____	What recommendations do you have for preventing other accidents of this type? _____ _____ _____ _____ _____ _____ _____ _____ _____
Teacher _____		